

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8093

08086

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Coleman's Worton</b>		c. LENGTH OF STAY IN life <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at home RFD Worton</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Demby</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 1, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>various</b>	
11c. BIRTHPLACE (State or foreign country) <b>Kent Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. Demby</b>		14. MOTHER'S MAIDEN NAME <b>Katee Garrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-30-2240</b>	
17. INFORMANT <b>Mary Demby RFD Worton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute right sided heart failure</b> 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>old age</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1961</b> to <b>July 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 17, 1961</b> , and that death occurred at <b>5:25 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Florence D. Joyce M.D.</b>		22b. DATE SIGNED <b>7/18/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Florence D. Joyce</b>		22d. ADDRESS <b>RFD Worton, Md.</b>	
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>		23b. DATE THEREOF <b>July 23 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Coleman's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>RFD Worton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel W. Waddy</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur B. Kinn</b>			

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08087											
1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Kent</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY in 1b <u>2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Worton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kent + Queen Anne's Hospital</u>						d. STREET ADDRESS <u>1 RFD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Dorsey</u>						4. DATE OF DEATH Month Day Year <u>July August 8 1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/6/61 7pm</u>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months Days <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Donald Brooks</u>						14. MOTHER'S MAIDEN NAME <u>Agnes Dorsey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mother</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Fetal atelectasis -</u> <u>762.0</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>7-6-1961</u> to <u>7-8-1961</u> , that (I) (we) last saw the deceased alive on <u>7-8-1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert W. Farr</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-9-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>						22d. ADDRESS <u>Chestertown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Coleman Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>(near) Worton Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walby</u> ADDRESS <u>Chestertown, Md.</u>						25a. REC'D BY REGISTRAR <u>JUL 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

2072212XVI

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1, 2, 3, and 4 may be retained by the hospital or attending physician. Item 1 should be filed in by the funeral director. Item 2 should be retained by the attending physician and completed. Item 3 should be retained by the funeral director. Item 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Filed 293 8-2-61 MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																
2095																
CERTIFICATE OF DEATH																
08083																
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>5 days, 10 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rock Hall,</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Dowling, Sr.</b> Last <b>Dowling, Sr.</b>					4. DATE OF DEATH Month <b>7</b> Day <b>2</b> Year <b>19 61</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/19/86</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>2</b>		IF UNDER 24 HRS. Hours <b>10</b> Min. <b>00</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sexton</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Dowling</b>					14. MOTHER'S MAIDEN NAME <b>Annie Joiner</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <b>220 34 9395</b>					17. INFORMANT <b>Bertha Dowling, Rock Hall, Md. (daughter)</b> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia with impending cardiac failure.</b> 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>493X</b> DUE TO (c) <b>493X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lymphocytic leukemia, acute</b>										INTERVAL BETWEEN ONSET AND DEATH						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Rock Hall</b>		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from <b>6/27/61</b> , 19 <b>61</b> , to <b>7/2/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7/2/61</b> , 19 <b>61</b> , and that death occurred on <b>7/2/61</b> , 19 <b>61</b> , from the causes and on the date stated above.										22a. SIGNATURE <b>William M. Latwood</b> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>7/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>			23d. LOCATION (City, town or county) <b>Rock Hall</b>		(State) <b>Md.</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b> ADDRESS <b>Church Hill. Md.</b>					25a. REC'D BY REGISTRAR <b>JUL 12 '61</b> DATE			25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>								

6203

6203

(M)

1902

Maryland

1902

Rock Hall,

5 days, 10 hrs.

Overstayed

x

Went to Queen Anne's Hospital

62

2

7

Howling, Dr.

James

(1)

73

Wife

x

White

Mrs

U.S.A.

Maryland

Genoa

Annie Taylor

John Howling

220 34 2222 Barton Howling, Rock Hall, Md. (damp)

Bo

Transmitted with 12 ending credit failure.

*[Handwritten notes and signatures]*



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8096

08089

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>		c. LENGTH OF STAY IN 1b <b>lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at home Piney Neck</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall Rural</b>	
f. STREET ADDRESS <b>Piney Neck</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Lee Edwards</b>		4. DATE OF DEATH Month Day Year <b>July 25, 1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/2/1890</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Boats</b>	
13. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>John Clarence Edwards</b>		16. MOTHER'S MAIDEN NAME <b>Georganna Ashley</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>218-16-6543</b>	
19. INFORMANT <b>Mrs. Nellie Edwards</b>		Address <b>Rock Hall, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Cardio Vascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Hypertension</b> (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1961</b> , to <b>July 23, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 23, 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Norbert C. Nitsch</b>		22b. DATE SIGNED <b>7/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Norbert C. Nitsch</b>		22d. ADDRESS <b>Rock Hall, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Rock Hall, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 28 '61</b>	
ADDRESS <b>Chestertown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

(M)

(1)

MEDICAL CERTIFICATION

277-1

1947-10-10

100

M



1  
FOR STATE  
HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08090

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Betterton(rural)</b>		c. LENGTH OF STAY IN b <b>Lifetime</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Betterton(rural)</b>		d. STREET ADDRESS <b>---</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Paul</b> First <b>L</b> Middle <b>Ellis</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 19, 1937</b>		9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b>		IF UNDER 24 HRS. Hours <b>---</b> Min. <b>---</b>			
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <b>Service</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Coast Guard</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Newton Ellis</b>						14. MOTHER'S MAIDEN NAME <b>Florence Willis</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Nov '60 Jul '61</b>						16. SOCIAL SECURITY NO. <b>214-30-9111</b>						17. INFORMANT Address <b>Newton Ellis Betterton, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull, and other multiple injuries (short)</b> 814X DECEASED WAS RIDING A MOTORCYCLE WHICH Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>struck a deer crossing the road in front of him, at about 12:30 AM today</b> (c) <b>---</b>																INTERVAL BETWEEN ONSET AND DEATH <b>---</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>---</b>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>See above</b>															
20c. TIME OF INJURY Month <b>7</b> Day <b>1</b> Year <b>61</b> Hour <b>---</b> Min. <b>---</b> Sec. <b>---</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway near Betterton</b>				20f. (City or town) (County) (State) <b>Kent Md.</b>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>Robert W. Farr</b>				EXAMINER'S NAME (Type) <b>Robert W. Farr</b>				M.D. <b>---</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>July 1, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/3/61</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Chestertown, Maryland</b>							
23. FUNERAL DIRECTOR <b>Victor N. Kennedy</b>				ADDRESS <b>Still Pond, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 5 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>							

M

I

6046 J. Neurosci., June 23, 2010 • 30(25):6042–6051

13

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

© 1997 Blackwell Ltd *Journal of Internal Medicine* 241: 321–327

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00091

1. PLACE OF DEATH  
a. COUNTY **Kent** MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Chestertown**  
c. LENGTH OF STAY IN b. **6 hr 40 min**  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Kent and Queen Annes Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)  
a. STATE **Maryland** b. COUNTY **Queen Anne**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Pondtown - Chestertown Rural**  
d. STREET ADDRESS  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **Ella** First Middle Last  
4. DATE OF DEATH **July 5 19 61** Month Day Year  
5. SEX **female** 6. COLOR OR RACE **colored** 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH **2-22-1933** 9. AGE (In years last birthday) **28** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Domestic** 10b. KIND OF BUSINESS OR INDUSTRY **homes** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**  
13. FATHER'S NAME **James Hines** 14. MOTHER'S MAIDEN NAME **Susie ~~Woods~~ Williams**  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address **Hospital records, Chestertown, Maryland**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Septic abortion and probable septicemia**  
DUE TO  
Conditions, if any, which gave rise to immediate cause (b)  
(a), stating the underlying cause last. DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒  
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒  
ACTUAL SIGNATURE **Robert W. Farr** M.D. DATE SIGNED **7/6/61**  
EXAMINER'S NAME (Type) **Robert W. Farr, M.D.** Address (Street, city, town, or county)  
22a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 22b. DATE THEREOF **7-8-1961** 22c. NAME OF CEMETERY OR CREMATORY **MT. PLEASANT CEMETERY** 22d. LOCATION (City, town, or country) (State) **POND TOWN, RURAL CHESTERTOWN, Md.**  
23. FUNERAL DIRECTOR ADDRESS **Edward Bellows, Millington, Md.** 24a. REC'D BY REGISTRAR **JUL 10 '61** 24b. REGISTRAR'S SIGNATURE **William L. Knease**



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8099

08092

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Millington</b> c. LENGTH OF STAY IN b. <b>1</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Golt</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Golt</b> d. STREET ADDRESS <b>Golt</b>				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
<b>3. NAME OF DECEASED</b> (Type or print) <b>George E. Hurd</b>		<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>10</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b>				<b>6. COLOR OR RACE</b> <b>White</b>				<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <b>August 15, 1899</b>				<b>9. AGE</b> (In years: IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) <b>61</b> yrs. Months <b>1</b> Days <b>6</b> Hours <b>1</b> Min.											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farm Labor</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>				<b>11. BIRTHPLACE</b> (Country & State or foreign country) <b>Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>																			
<b>13. FATHER'S NAME</b> <b>Edward Hurd</b>				<b>14. MOTHER'S M maiden name</b> <b>Katie Kemp</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>220-26-2893</b>				<b>17. INFORMANT</b> <b>Mrs. Evelyn F. Hurd, Golt, Md.</b>															
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>2</b> (c)												INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>																			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.</b>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>1</b> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from July 10, 1961, to July 12, 1961, that (I) (we) last saw the deceased alive on July 10, 1961, and that death occurred at 1:30 P.M. from the causes and on the date stated above.</b>																															
<b>22a. SIGNATURE</b> <i>[Signature]</i> <b>22b. DATE SIGNED</b> <b>July 12, 1961</b>																															
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>22d. ADDRESS</b> <b>22e. REC'D BY REGISTRAR</b> <b>22f. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>																															
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>July 13, 1961</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Townsend Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Townsend, Del.</b>																			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>																															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 may be retained by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8100  
CERTIFICATE OF DEATH

88093

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Watson Boarding Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grasonville</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Herman Morris</b>		4. DATE OF DEATH <b>July 23, 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>No Record 1895</b>	
9. AGE (In years, last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>No Record</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W.W. 1</b>		16. SOCIAL SECURITY NO. <b>219 07 5506</b>	
17. INFORMANT <b>Sarah Watson,</b>		Address <b>Millington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Heart attack (Coronary sclerosis)</b> 002X DUE TO <b>Coronary sclerosis</b> Conditions, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Tuberculosis of the lung</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. INTERVAL BETWEEN ONSET AND DEATH <b>2-3 years</b> <b>4 years?</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>week 15, 1961</b> to <b>April 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 14, 1961</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Geza Koralewski</b>		22b. DATE SIGNED <b>July 24, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEZA KORALEWSKI</b>		22d. ADDRESS <b>MILLINGTON, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 25, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rileys Neck Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Millington, Rural. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		25. REC'D BY REGISTRAR <b>JUL 27 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Walter S. Harris</b>		25c. ADDRESS	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

98094

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>At Home RFD # 2</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b> d. STREET ADDRESS <b>RFD # 2</b> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <b>Joseph C. Quinn</b> First Middle Last 4. DATE OF DEATH <b>July 31, 1961</b> Month Day Year		5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Aug. 1, 1897</b> 9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b> 11. BIRTHPLACE (State or foreign country) <b>Kent CO. Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph C. Quinn</b> 14. MOTHER'S MAIDEN NAME <b>Abbie Estella Loller</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>216-40-4525</b> 17. INFORMANT Address <b>Francis A. Quinn Chestertown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rifle wound of head</b> DUE TO (b) <b>Rifle was held in mouth</b> DUE TO (c) <b>shot</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Depressed for two months</b>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Self administered with 22 rifle</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>10:00 7/31 61</b> Hour a.m. <b>7:31</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b> 20f. (City or town) (County) (State) <b>hr. Chestertown Kent, Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/1/61</b> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>8/3/61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Chestertown, Md.</b>		23. FUNERAL DIRECTOR <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b> 24a. REC'D BY REGISTRAR <b>AUG 3 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8102  
CERTIFICATE OF DEATH

C8095

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> c. LENGTH OF STAY IN 1b <u>40 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>125 Plos. Terrace</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> d. STREET ADDRESS <u>125 Plos. Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>R. Lee Robinson</u> First Middle Last 4. DATE OF DEATH <u>July 29/61</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 13 1893</u> 9. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday Months Days Hours Min. <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mail Clerk</u> 13. FATHER'S NAME <u>Edward Robinson</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Chestertown Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and date of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Jones</u> 17. INFORMANT <u>Mrs. Susie H. Robinson</u> Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery infarct</u> 420.1 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary artery disease</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1950</u> to <u>July 29 1961</u> that (I) (we) last saw the deceased alive on <u>July 25 1961</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A.C. Dick</u> 22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7-30-61</u> 22d. ADDRESS <u>Chestertown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Aug. 1, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chestertown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u> ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Richard L. Kraus</u>	





may be released by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8103

1  
M  
X  
I

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08096

1 PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN life Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Duyer Apt. (at Home)		d. STREET ADDRESS Duyer Apt. Maple Ave.	
3 NAME OF DECEASED (Type or print) First Naomi Middle Davies Last Russell		4. DATE OF DEATH Month July 10, 1961 Day 19 Year 19	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1893
9. AGE (in years last birthday) yrs 68		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11 BIRTHPLACE (State or foreign country) Kent Co. Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Landon Davies		14. MOTHER'S MAIDEN NAME Naomi Blackiston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 219-36-6906	
17. INFORMANT John Russell		18. ADDRESS 152 Brookwood Road Ellicott City, Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct			
DUE TO (b) Coronary artery disease			
DUE TO (c) Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 36 hours			
11 years			
11 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED Where at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1-6-55 to 7-10-1961, that (I) (we) last saw the deceased alive on 7-9-1961, and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE A. C. Dick		22b. DATE 7/11/61	
22c. PHYSICIAN'S NAME (Type) A. C. Dick		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/12/61	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DATE JUL 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			



8104

## CERTIFICATE OF DEATH

Reg. Dist. No. 08097

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN It <b>2 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kent &amp; Queen Anne Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Urban</b> Last <b>Stein</b>		4. DATE OF DEATH <b>July 29, 1961</b> 19	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1906</b>
9. AGE (In years last birthday) <b>55</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>12</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bookkeeper (ret)</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Urban</b>		14. MOTHER'S MAIDEN NAME <b>Mary Urban</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>145-03-2798</b>	
17. INFORMANT <b>Hospital Records - Chestertown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Cerebral vas. Thrombosis &amp; RT Hemiplegia</b> DUE TO (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>2 months</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-31-</b> 19 <b>61</b> to <b>7-29-</b> 19 <b>61</b> , that I last saw the deceased alive on <b>7-29-</b> 19 <b>61</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry Paul Ross</b>		DATE SIGNED <b>7/29/61</b>	
PHYSICIAN'S NAME (Type) <b>Harry Paul Ross</b>		<b>Chestertown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/2/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		24a. REC'D BY REGISTRAR <b>AUG 3 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Huns</b>

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8105  
88098

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kent and Queen Anne Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Locust Grove</b> d. STREET ADDRESS <b>X</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George W. Webb</b> First Middle Last 4. DATE OF DEATH <b>July 13, 1961</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>January 18, 1889</b> 9. AGE (In years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b> 11. BIRTHPLACE (Country & State or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Webb</b> 14. MOTHER'S MAIDEN NAME <b>Katie Roeder</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>XXXX-XX-XXXX</b> 17. INFORMANT <b>Mrs. Bessie O. Webb, Rural Kennedyville, Md.</b> Address <b>XXXXXX</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Coronary Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Ventricular Fibrillation</b> <b>Coronary Thrombosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3rd Coronary Arteriosclerosis - mild</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>3 minutes</b> <b>7 DAYS</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/8</b> ..... 19 <b>61</b> , to <b>7/13</b> ..... 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7/13</b> ..... 19 <b>61</b> , and that death occurred at <b>4:00 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas J. Solon</b> 22c. PHYSICIAN'S NAME (Type) <b>Thomas J. Solon</b>		22b. DATE SIGNED <b>7/14/61</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Chestertown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 16, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Church Hill, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b> ADDRESS <b>Millington, Md.</b>		25a. REC'D BY REGISTRAR <b>Jul 18 '61</b> 25b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08093

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (Melitota)</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Home (melitota)</b>		e. STREET ADDRESS <b>RFD</b>	
3. NAME OF DECEASED (Type or print) First <b>Romie</b> Middle <b>Williams</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Sept. 16, 1900</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min. <b>59</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Labor</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Kent Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Washington Williams</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Houston</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>YES</b>		17. INFORMANT <b>Verma Williams RFD Chestertown, Md. Wife</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephritis</b> DUE TO <b>593X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>593X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>June</b> Day <b>10</b> Year <b>61</b> Hour <b>6</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rock Hall, Maryland</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1961</b> to <b>7/1, 1961</b> , that (I) (we) last saw the deceased alive on <b>7/1/61</b> 19 <b>61</b> , and that death occurred at <b>5P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Eugene Kester</b>		22b. DATE <b>July 1, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Eugene Kester</b>		22d. ADDRESS <b>Rock Hall, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 5, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pomona Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>near - Chestertown, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Renneth Wadby</b>		25a. REC'D BY REGISTRAR <b>Jul 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8107											
CERTIFICATE OF DEATH											
08100											
1. PLACE OF DEATH a. COUNTY <b>Kent</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>						c. LENGTH OF STAY IN 1b <b>4 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Annes</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>VINCENT</b> Middle <b>JOSEPH</b> Last <b>WILLIAMS</b>						4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1896</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing Supplies Pennsylvania</b>				11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Joseph Williams</b>						14. MOTHER'S MAIDEN NAME <b>Margaret O'Erian</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>198-09-4997</b>		17. INFORMANT <b>Hospital Records, Chestertown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right heart failure</b>											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary fibrosis due to old Pulmonary Tbc.</b>											
DUE TO (c) <b>30-40 years</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>Polycythemia due to 18, part 1; and right sided pneumothorax</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7/6</b> to <b>7/28</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7/28</b> , 19 <b>61</b> , and that death occurred at <b>7:30</b> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert W. Farr</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>July 28, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>						22d. ADDRESS <b>Chestertown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>7/29/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Crematory</b>				23d. LOCATION (City, town or county) (State) <b>Wilmington, Delaware</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>				ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

7039

1998

1022

2005-2006

A. Davis

## EXPERIMENT V

03/11/20

range of

၁၁၂၆။ အနုပညာ - အနုပညာ

Copyright © 2000

1991-1992

Winnipeg, Manitoba, Canada

Reference is made to the fact that the above information is for the purpose of the above mentioned project and is not to be used for any other purpose.

100-716

1092 J. B. Clark

TEMPERATURE